

## SECTION 1915 (c) WAIVER FORMAT

1. The State of Alabama requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

This is a request for a model waiver.

a. Yes

b.	<b>x</b>	No
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If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

This waiver is requested for a period of (check one) :

a. 3 years (initial waiver)

b. **x** 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

a. Nursing facility (NF)

b.     **X**     Intermediate care facility for  
mentally retarded or persons with  
related conditions (ICF/MR)

c. Hospital

d. NF (served in hospital)

e. ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

- a. \_\_\_\_\_ aged (age 65 and older)
- b. \_\_\_\_\_ disabled
- c. \_\_\_\_\_ aged and disabled
- d.   **X**   mentally retarded
- e. \_\_\_\_\_ developmentally disabled
- f. \_\_\_\_\_ mentally retarded and  
developmentally disabled
- g. \_\_\_\_\_ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

- a.   **X**   Waiver services are limited to the following age groups (specify):  
**Three years of age and above.**
- b. \_\_\_\_\_ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
- c. \_\_\_\_\_ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.
- d.   **X**   Other criteria. (Specify):  
**With the exception of crisis intervention**

services, the cost of home and community-based services planned and received by the person under this waiver shall not exceed \$ 25,000 per waiver year. Also, priority access to this waiver shall be given to people on a verified waiting list.

e. Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.
6. This waiver program includes individuals who are eligible under medically needy groups.  
a. \_\_\_\_\_ Yes b.   **X**   No
7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.  
a. \_\_\_\_\_ Yes b.   **X**   No c. \_\_\_\_\_ N/A
8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.  
a. \_\_\_\_\_ Yes b.   **X**   No
9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.  
a. \_\_\_\_\_ Yes b.   **X**   No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

a.   **X**   Yes

b.            No

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a.            Case management

b.            Homemaker

c.            Home health aide services

d.   **X**   Personal care services

e.   **X**   Respite care

f.            Adult day health

g.   **X**   Habilitation

  **X**   Residential habilitation

  **X**   Day habilitation

  **X**   Prevocational services

  **X**   Supported employment services

           Educational services

h.   **X**   Environmental accessibility  
adaptations

i.   **X**   Skilled nursing

j.            Transportation

k.   **X**   Specialized medical equipment and  
supplies

- l. \_\_\_\_\_ Chore services
- m. \_\_\_\_\_ Personal Emergency Response Systems
- n. \_\_\_\_\_ Companion services
- o. \_\_\_\_\_ Private duty nursing
- p. \_\_\_\_\_ Family training
- q. \_\_\_\_\_ Attendant care
- r. \_\_\_\_\_ Adult Residential Care

\_\_\_\_\_ Adult foster care

\_\_\_\_\_ Assisted living

- s. \_\_\_\_\_ Extended State plan services (Check all that apply):

\_\_\_\_\_ Physician services

\_\_\_\_\_ Home health care services

\_\_\_\_\_ Physical therapy services

\_\_\_\_\_ Occupational therapy services

\_\_\_\_\_ Speech, hearing and language services

\_\_\_\_\_ Prescribed drugs

\_\_\_\_\_ Other (specify):

- t.   X   Other services (specify):

**Physical Therapy**  
**Occupational Therapy**  
**Speech and Language Therapy**  
**Behavior Therapy**  
**Community Specialist**  
**Crisis Intervention**

- u. \_\_\_\_\_ The following services will be provided to individuals with

chronic mental illness:

- \_\_\_\_\_ Day treatment/Partial hospitalization
- \_\_\_\_\_ Psychosocial rehabilitation
- \_\_\_\_\_ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.
13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.
14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):
- a.   **X**   When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).
  - b. \_\_\_\_\_ Meals furnished as part of a program of adult day health

services.

- c. \_\_\_\_\_ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:
- a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:
1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);
  2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and
  3. Assurance that all facilities covered by

section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

- b. The agency will provide for an evaluation and periodic reevaluations, at least annually) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.
- c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:
  - 1. Informed of any feasible alternatives under the waiver; and
  - 2. Given the choice of either institutional or home and community-based services.
- d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
- e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have



been made in that fiscal year had the waiver not been granted.

- f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.
- g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.
- h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
- i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a.   **X**   Yes                      b.            No

STATE:   Alabama  

DATE: 10/01/2007

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. \_\_\_\_\_ Yes                      b.   X   No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of   October 1, 2005   is requested.

19. The State contact person for this request is   Monica Abron  , who can be reached by telephone at   ( 334 )242 5642  .

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's

authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print Name: **Carol H. Steckel**

Title: **Commissioner, Alabama Dept. of Medicaid**

Date:

APPENDIX A ADMINISTRATION

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

\_\_\_\_\_ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

  **X**   The waiver will be operated by the **Department of Mental Health and Mental Retardation**, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

\_\_\_\_\_ The waiver will be operated by \_\_\_\_\_, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

a. No      **Case Management**

b. No      **Homemaker:**

c. No      **Home Health Aide Services:**

d. Yes      **Personal Care Services:**

X      Other service definition (Specify):

**Definition**

Personal Care Services include assistance with any activity of daily living (ADL) or instrumental activity of daily living (IADL). Assistance for ADLs includes bathing, toileting, transfer and ambulation, skin care, grooming, dressing, extension of therapies and exercise, routine care of adaptive equipment primarily involving cleaning as needed, meal preparation, assistance with eating, and incidental household cleaning and laundry. IADLs include shopping, banking, budgeting, using public transportation, social interaction, recreation and leisure activities. Assistance with IADLs includes accompaniment, coaching and minor problem-solving necessary to achieve the objectives of increased independence, productivity and inclusion in the community.

Personal Care can also include supporting a person at an integrated worksite where the individual is paid a competitive wage. There will be a separate code for this service, provided at the worksite, to distinguish it from other personal care activities, effective in Fiscal Year 2007.

Personal care attendants may transport consumers in their own (the attendant's) vehicles as an incidental component of this service. For this component to be reimbursed, the personal care attendant must be needed to support the consumer in accessing the community, and not merely to provide transportation. Additional payment will be made for mileage and the provider's cost of an insurance waiver to cover any harm that might befall the consumer as a result of being transported. The attendant must have a valid Alabama driver's license and his/her own insurance coverage as required by State law. The provider agency shall assure the attendant has a good driving record and is in-serviced on safety procedures when transporting a consumer. This service will provide transportation into the community to shop, attend recreational and civic events, go to work and participate in People First and other community building activities. It shall not replace transportation that is already reimbursable under day or residential habilitation nor the Medicaid non-emergency medical transportation program. The planning team must also assure the most cost effective means of transportation, which would include public transport where available. Transportation by a personal care attendant is not intended to replace generic transportation nor to be used merely for convenience.

Personal care under the waiver may also include general supervision and protective oversight reasonable to accomplishing of health, safety and inclusion. The worker may directly perform some activities and support the client in learning how to perform others; the planning team (composed at minimum of the person and family, and a case manager or community specialist) shall determine the composition of the service and assure it does not duplicate, nor is duplicated by, any other service provided to the individual. A written description of what the personal care worker will provide to the person is required to be submitted to the state as part of or in addition to the plan of care, and will require approval by the Division of Mental Retardation and be subject to review by the Single State Agency for Medicaid.

While in general personal care will not be approved for a person living in a group home or other residential setting, the Division of Mental Retardation may approve it for specific purposes that are not duplicative.

The plan of care or an addendum shall specify any special requirements for training, more than basic training, which may be needed to support the individual. Parents and other caretakers shall be key informers on the matter of special training, and will be encouraged to participate in the training and supervision of the worker.

When this service is provided to minor children living with their parents or guardians, it shall not supplant the cost and provision of support ordinarily provided by parents to children without disabilities, nor shall it supplant educationally related services and support that is the responsibility of local education authorities. Otherwise, the only limitation on hours provided is the individual's documented need for the service as an alternative to institutional care and the reasonable cost effectiveness of his or her plan.

#### **Place of Service / Unit of Service**

There is no restriction on the place of service so long as the person is eligible for the waiver in that setting and no duplication of payment occurs. Payment is for a 15 minute unit of service, not including worker's time of travel to and from the place of work.

#### **Provider Qualifications**

Provider qualifications are specified in Appendix B-2.

#### **Relatives as Providers**

Personal Care Workers shall not be members of the immediate family (parents, spouses children or siblings) of the person being supported, nor may they be legally obligated in any other way to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered.

Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

**Relation to State Plan Services**

Personal Care Services under the State Plan differ in service definition from the services to be offered under the waiver.

e. Yes      **Respite care:**

X Other service definition (Specify):

Respite care is a service provided in or outside a family's home to temporarily relieve the unpaid primary caregiver. Respite care provides short-term care to an adult or child for a brief period of rest or relief for the family from day to day care giving for a dependent family member.

Respite is intended for participants whose primary caregivers typically are the same persons day after day (e.g. family members and/or adult family foster care providers), and is provided during those portions of the day when the caregivers typically provide care. Relief needs of hourly or shift staff workers will be accommodated by staffing substitutions, plan adjustments, or location changes, and not by respite care. Respite care typically is scheduled in advance, but it can also serve as relief in a crisis situation. As crisis relief, out of home respite can also allow time and opportunity for assessment, planning and intervention to try to re-establish the person in his home, or if necessary, to locate another home for him.

Some consumers are institutionalized because their community supports become exhausted, or because they don't know how to cope with an increasingly challenging behavior, or due to the loss/incapacitation of a caregiver. The scope of out of home respite will allow quick response to place the person in an alternate setting and provide intensive evaluation and planning for return, with or without additional intervention and supports. Planning will be made for alternate residential supports if return is not possible. The goal is to avoid institutionalization. Respite care is highly cost effective as an alternative to long term placement in an ICF/MR.

Respite care is dependent on the individual's needs as set forth in the plan of care and requires approval by the Division of Mental Retardation, subject to review by the Alabama Medicaid Agency. The limitation on either in home or out of home Respite Care shall be 1080 hours or 45 days per waiver participant per waiver year.

Respite care out of the home may be provided in a certified group home or ICF/MR. In addition, if the recipient is less than 21 years of age, respite care out of the home may be provided in a JCAHO Accredited Hospital or Residential Treatment Facility (RTF). While a recipient is receiving out of home respite, no additional Medicaid reimbursement will be made for other services in the institution. The requirements for the agency and personnel providing the respite are contained in appendix B-2-a.

FFP is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

f. No      **Adult day health:**

g. Yes      **Habilitation:**

X      **Other service definitions follow for Residential Habilitation, Day Habilitation, Prevocational Employment and Supported Employment:**

**Residential Habilitation**

Residential habilitation services provide care, supervision, and skills training in activities of daily living, home management and community integration. In this waiver, residential habilitation services are provided to recipients in their own homes, but not in group homes or other facilities. A unit of service is one hour. The place of service will primarily be the person's home, but may include services in the community to promote opportunities for inclusion, socialization, and recreation.

Residential habilitation goals must relate to identified, planned goals. Training and supervision of staff by a QMRP shall assure the staff is prepared to carry out the necessary training and support functions to achieve these goals. Initial training requirements are specified in Appendix B-2; these must be met prior to the staff beginning work. Additional training to specifically address and further the goals in the individual's plan may occur on the job. Consumers and family members shall be included in the planning, and shall be offered and encouraged to use the opportunity to participate in the training and supervision of the staff.

The service includes the following:

- Habilitation training and intervention in the areas of self-care, sensory/motor development, interpersonal skills, communication, behavior shaping, community living skills, mobility, health care, socialization, community inclusion, money management, pursuit of leisure and recreational activities and household responsibilities. Training and intervention may consist of incidental learning in addition to formal training plans, and will also encompass modification of the physical and/or social environment, meaning, changing factors that impede progress (i.e. moving a chair, substituting elcro closures for buttons or shoe laces, changing peoples' attitudes toward the person, opening a door for someone, etc.) and provision of direct support, as alternatives to formal habilitative training.
- Habilitation supplies and equipment; and
- Transportation costs to transport individuals to day programs, social events or community activities when public transportation and/or transportation covered under the Medicaid state plan are not available will be included in payments made to providers of residential habilitation.



Residential Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service.

The service excludes the following:

- Services, directly or indirectly, provided by a member of the individual's immediate family;
- Routine care and supervision which would be expected to be provided by a family;
- Activities or supervision for which a payment is made by a source other than Medicaid; and
- Room and board costs.

Providers of residential habilitation must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

### **Day Habilitation Services**

Day habilitation includes planning, training, coordination and support to enable and increase independent functioning, physical health and development, communication development, cognitive training, socialization, community integration, domestic and economic management, behavior management, responsibility and self direction. Staff may provide assistance/training in daily living activities and instruction in the skills necessary for independent pursuit of leisure time/recreation activities. Social and other adaptive skills building activities such as expressive therapy, prescribed use of art, music, drama or movement may be used to modify ineffective learning patterns and/or influence change in behavior.

Transportation cost to transport individuals to places such as day programs, social events or community activities when public transportation and/or transportation covered under the State Plan is not available, accessible or desirable due to the functional limitations of the client will be included in the rate paid to providers for this service. Day Habilitation service workers may transport consumers in their own vehicles as an incidental component of this service. Providers of day habilitation must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

Qualifications of the providers of day habilitation training are contained in Appendix B-2.

### **Prevocational Services**

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task

completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Check one:

\_\_\_\_\_ Individuals will not be compensated for prevocational services.

  X   When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

Providers of prevocational services must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

### **Supported Employment Services**

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of

1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1.   X   Yes                      2.        No

Providers of supported employment must be certified by the Department of Mental Health and Mental Retardation. This service is necessary to prevent institutionalization and its cost-effectiveness is demonstrated in Appendix G.

**h.   Yes   Environmental Accessibility Adaptations**

  X   Other service definition (Specify):

**Environmental Accessibility Adaptations**

Those physical adaptations to the home, required by the recipient's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are of general utility and not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

The individual's home may be a house or an apartment that is owned, rented or leased. Adaptations to the work environment covered by the Americans with

Disabilities Act, or those that are the responsibility of other agencies, are not covered. Covered adaptations of rented or leased homes should be those extraordinary alterations that are uniquely needed by the individual and for which the property owner would not ordinarily be responsible

Total costs of environmental accessibility adaptations shall not exceed \$5,000 per year, per individual.

i. Yes      **Skilled nursing:**

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

X      **Other service definition (Specify):**

Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Services consist of nursing procedures that meet the person's health needs as ordered by a physician. Services will be billed by the hour. There is no restriction on the place of service.

j. No      **Transportation:**

\_\_\_\_\_ Other service definition (Specify):

k. Yes      **Specialized Medical Equipment and Supplies**

X      Other service definition (Specify):

**Specialized Medical Equipment and Supplies**

Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. All items shall meet applicable standards of manufacture, design and installation. Costs are limited to \$5,000 per year, per individual.

l. No      **Chore services:**

- m. No      **Personal Emergency Response Systems (PERS)**
- n. No      **Adult companion services:**
- o. No      **Private duty nursing:**
- q. No      **Attendant care services:**
- r. No      **Adult Residential Care (Check all that apply):**
- s. Yes      **Other waiver services** which are cost-effective and necessary to prevent institutionalization (Specify): **Speech and Language Therapy, Physical Therapy, Occupational Therapy, Behavior Therapy, Community Specialist Services, and Crisis Intervention.**

**Speech and Language Therapy**

Speech and language therapy are diagnostic, screening, preventive, corrective services provided on an individual basis, when referred by a physician (M.D., D.O.). These services may include:

Screening and evaluation of individuals' speech and hearing functions and comprehensive speech and language evaluations when so indicated;

Participation in the continuing interdisciplinary evaluation of individuals for purposes of implementing, monitoring and following up on individuals' habilitation programs; and

Treatment services as an extension of the evaluation process that include:

- consulting with others working with the individual for speech education and improvement,
- designing specialized programs for developing an individual's communication skills comprehension and expression.

Provision of this service will prevent institutional placement.

Therapist may also provide training to staff and caregivers (such as a client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Services must be listed on the care plan and prescribed by a physician. The need for service must be documented in the case record. Services shall be provided and billed by the hour. Speech/language therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, service is limited to recipients age 21 and over. Group therapy will not be reimbursed.

Providers of service must maintain a service log that documents specific days on which speech and language therapy services were delivered. Provider qualifications are found in Appendix B-2.

### **Physical Therapy**

Physical therapy is physician prescribed treatment of an individual by the employment of effective properties of physical measures and the use of therapeutic exercises and rehabilitative procedures with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and providing treatment training programs that are designed to:

- preserve and improve abilities for independent function, such as range of motion, strength, tolerance, coordination and facility performing activities of daily living; and
- prevent irreducible progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations and sensory stimulation.

Provision of this service will prevent institutional placement.

Therapist may also provide consultation and training to staff or caregivers (such as client's family and/or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Documentation in the case record must justify the need for service. Services must be listed on the care plan and be provided and billed by the hour. Physical therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy is not allowed.

Providers of service must maintain a service log that documents specific days on which physical therapy services were delivered. Provider qualifications are found in Appendix B-2.

### **Occupational Therapy**

Occupational therapy is the application of occupation-oriented or goal-oriented activity to achieve optimum functioning, to prevent dysfunction, and to promote health. The term "occupation" as used in occupational therapy refers to any activity engaged in for evaluation, specifying, and treating problems interfering with functional performances. Services include assisting in the evaluation of an individual to determine level of functioning by applying diagnostic and prognostic tasks and guiding and treating individuals in the prescribed therapy to secure and/or obtain necessary functioning. Provision of this service will prevent institutional placement.

Therapist may also provide consultation and training to staff or

caregivers (such as client's family and /or foster family). Services to direct caregivers will be allowed when the service to caregivers is for the direct benefit of the recipient and is necessary to enable the recipient to be cared for outside of an institution.

Services must be prescribed by a physician and be provided on an individual basis. The need for service must be documented in the case record. Services must be listed on the care plan and be provided and billed by the hour. Occupational therapy is covered under the State Plan for eligible recipients as a result of an EPSDT screening. Therefore, this service is limited to recipients age 21 and over. Group therapy is not allowed.

Providers of service must maintain a service log that documents specific days on which occupational therapy services were delivered. Provider qualifications are found in Appendix B-2.

### **Behavior Therapy**

Behavior Therapy Services provide systematic functional behavior analysis, behavior support plan (BSP) development, consultation, environmental manipulation and training to implement the BSP, for individuals whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration, whose health is at risk, and/or who may otherwise require movement to a more restrictive environment. Behavior therapy may also include consultation provided to families, other caretakers, and habilitation services providers. Behavior therapy shall place primary emphasis on the development of desirable adaptive behavior rather than merely the elimination or suppression of undesirable behavior. A behavior support plan may only be implemented after positive behavioral approaches have been tried, and it's continued use must be reviewed thirty days. The unit of service is 15-minutes.

The Behavior Therapy waiver service is comprised of two general categories of service tasks. These are (1) development of a Behavior Support Plan (BSP) and (2) implementation of a BSP. In addition, this waiver service has three service levels: two professional and one technical, each with its own procedure code and rate of payment. The service levels are distinguished by the qualifications of the service provider and by supervision requirements. Both professional and technical level service providers may perform tasks within both service categories, adhering to supervision requirements that are described under provider qualifications.

The two professional service provider levels are distinguished by the qualifications of the therapist. Both require advanced degrees and specialization, but the top level also requires board certification in behavior analysis. The third service provider level is technical and requires that the person providing the service be under supervision to perform behavior therapy tasks. There is a different code and rate for each of the three service provider levels.

The table that follows lists types of tasks that meet criteria for billing for Behavior Therapy Services. Tasks listed are intended to be interpreted broadly to include any activities related to BSP development and implementation recognized in the field of behavior analysis.

Behavior Support Plan Development
Functional Analysis/Assessment (can include, but is not limited to, experimental analog procedures, conducting interviews, completion of screening measures, direct observation, review of ABC data, and other activities related to gathering information regarding the function of behavior)
ID/define target behaviors (includes behaviors to decrease and/or those to increase)
ID/assess psychiatric symptoms, if applicable
Participate in Interdisciplinary Team (IDT) meetings for BSP planning/development
ID/describe preventive strategies/other interventions
Write the plan (includes writing of BSP/psychotropic medication plan, if appropriate, as well as writing of addendum/revisions to the plan)
Implement baseline and analyze baseline data (includes training staff regarding baseline data collection)
Conduct reinforcer/preference assessment
Design data sheets
Behavior Support Plan Implementation
Present BSP/psychotropic medication plan for approval by Behavior Review Committee (BRC) and Human Rights Committee (HRC)
Periodic BSP follow-up and revision (includes activities such as reliability checks, attending IDT meetings related to BSP implementation and follow-up,)
Progress/evaluation reports
Activities evaluating impact of psychotropic medications
Staff training relevant to the BSP (includes initial and any follow-up training related to the BSP/psychotropic medication plan/use of data sheets, etc.)
Data entry, graphing, summary

Average 15-minute units of Behavior Therapy Services required per person per year range from 120 to 600 units. About one third of any significant behavior analysis effort consists of tasks that could be provided by technical level providers, with supervision. Therefore, the maximum units per year of both professional and technician level units in combination cannot exceed 600 and the maximum units of professional level cannot exceed 400. Maximum units of Technician level service are the balance between billed professional level units and the combined maximum per year. Professional level providers may provide more than the 400 unit limit, but these additional units will be paid at the Technician level. Providers of service must document which tasks are provided by date performed in addition to their clinical notes. Group therapy will not be reimbursed.

Service providers who identify individuals who require Behavior Therapy services in excess of the caps indicated above may request



consideration for approval of additional service units by the Director of Psychological and Behavioral Services in the Division of Mental Retardation of the DMH/MR. Detailed explanations (accompanied by documentation supporting the explanations) regarding how additional units of service will benefit the individual, data supporting the need for additional services, the written Behavior Support Plan, and documentation indicating how all of the units of service provided up to that point have been used will be required for review. Additional service units will be approved if sufficient evidence is presented to justify the need. There will be limits set regarding the number of units approved at that time. If there is insufficient evidence to support the request for additional service units, the request will be denied.

Providers of service must maintain a service log that documents specific days and hours on which behavior therapy services were delivered.

This service is necessary to prevent institutionalization. Provider qualifications are found in Appendix B-2.

### **Community Specialist Services**

Community Specialist Services include professional observation and assessment, individualized program design and implementation, training of consumers and family members, consultation with caregivers and other agencies, and monitoring and evaluation of planning and service outcomes. The functions outlined for this service differs from case management in that these functions will incorporate person-centered planning, whereas case management does not. The service may also, at the choice of the consumer or family, include advocating for the consumer and assisting him or her in locating and accessing services and supports. Here again, these functions differ from case management in that activities of planning and implementing services with self-determination are the focus. The provider must meet QMRP qualifications and be free of any conflict of interest with other providers serving the consumer. The services of the community specialist will assist the consumer and his caregivers to design and implement specialized programs to enhance self-direction, independent living skills, community integration, social, leisure and recreational skills, and behavior management. A community specialist with expertise in person-centered planning may also be selected by the consumer to facilitate the interdisciplinary planning team meeting.

Targeted case managers will continue to perform traditional duties of intake, completion of paperwork regarding eligibility, serving in the capacity of referral and resources locating, monitoring and assessment.

The planning team shall first ensure that provision of this service does not duplicate the provision of any other services, including Targeted Case Management provided outside the scope of the waiver. The community specialist will frequently be involved for only a short time (30 to 60 days); in such an instance, the functions will not overlap with case management. If the consumer or family chooses to have the community specialist remain involved for a longer period

of time, the targeted case manager will need only visit the person every 180 days, and call the person at 90-day intervals to ensure services actually are being delivered and are satisfactory. The community specialist will share information with the case manager quarterly in an effort to remain abreast of the client's needs and condition. A community specialist who facilitates the planning meeting for a person shall not have any conflict of interest with any provider who may wish to serve the person.

This service is a cost effective and necessary alternative to placement in an ICF-MR. A unit of service is one hour.

### **Crisis Intervention**

Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or of others and/or to result in the individual's removal from his current living arrangement.

Crisis intervention may be provided in any setting in which the consumer resides or participates in a program. The service includes consultation with family members, providers and other caretakers to design and implement individualized crisis treatment plans and provide additional direct services as needed to stabilize the situation.

Individuals with mental retardation are occasionally at risk of being moved from their residences to institutional settings because the person, or his or family members or other caretakers, are unable to cope with short term, intense crisis situations. Crisis intervention can respond intensively to resolve the crisis and prevent the dislocation of the person at risk. The consultation which is provided to caregivers also helps to avoid or lessen future crises. This service is a cost effective alternative to placement in an ICF-MR.

Crisis intervention services are expected to be of brief duration (8 weeks, maximum). When services of a greater duration are required, the individual shall be transitioned to a more appropriate service program or setting. There are two levels of staff, professional and technician. A unit of service is one hour. Qualifications for providers of this service are defined in Appendix B-2.

When the need for this service arises, the service will be added to the plan of care for the person. A separate crisis intervention plan will be developed to define in detail the activities and supports that will be provided. All crisis intervention services shall be approved by the regional community service office of the DMH/MR prior to the service being initiated.

Crisis intervention services will not count against the \$25,000 per person per year cap in this waiver, since the need for the service cannot accurately be predicted and planned for ahead of time.

Specific crisis intervention service components may include the

following:

- Analyzing the psychological, social and ecological components of extreme dysfunctional behavior or other factors contributing to the crisis;
- Assessing which components are the most effective targets of intervention for the short term amelioration of the crisis;
- Developing and writing an intervention plan;
- Consulting and, in some cases, negotiating with those connected to the crisis in order to implement planned interventions, and following-up to ensure positive outcomes from interventions or to make adjustments to interventions;
- Providing intensive direct supervision when a consumer is physically aggressive or there is concern that the consumer may take actions that threaten the health and safety of self and others;
- Assisting the consumer with self care when the primary caregiver is unable to do so because of the nature of the consumer's crisis situation; and
- Directly counseling or developing alternative positive experiences for consumers who experience severe anxiety and grief when changes occur with job, living arrangement, primary care giver, death of loved one, etc.

Providers of service must maintain a service log that documents specific days and hours on which crisis intervention services were delivered. Provider qualifications are found in Appendix B-2.

t. No **Extended State plan services:**

u. No **Services for individuals with chronic mental illness:**

## APPENDIX B-2

### PROVIDER QUALIFICATIONS

#### A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, State Administration Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION/ACCREDITATION	OTHER STANDARD
<b>Personal Care Services</b>	<ul style="list-style-type: none"> <li>Employee of or under contract with an Agency</li> </ul>			<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum</li> </ul>
<b>Respite Care</b>	<ul style="list-style-type: none"> <li>In- Home:</li> <li>Employee of an Agency</li> <li>Out of Home:</li> <li>Community Residential Facility,</li> <li>ICF/MR, or</li> <li>Hospital or Residential Treatment Facility</li> </ul>		<ul style="list-style-type: none"> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> <li>Certified by Alabama Department of Public Health</li> <li>JACHO Accredited</li> </ul>	<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum</li> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Residential Habilitation</b>	<ul style="list-style-type: none"> <li>Employee of a certified Community Residential Agency</li> </ul>		<ul style="list-style-type: none"> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> </ul>	<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Day Habilitation</b>	<ul style="list-style-type: none"> <li>Certified Day Program</li> </ul>		<ul style="list-style-type: none"> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> </ul>	<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Prevocational Services</b>	<ul style="list-style-type: none"> <li>Certified Prevocational Program</li> </ul>		<ul style="list-style-type: none"> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> </ul>	<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum</li> </ul>
<b>Supported Employment</b>	<ul style="list-style-type: none"> <li>Certified Supported Employment Program</li> </ul>		<ul style="list-style-type: none"> <li>Al. Code Chapters 580-3-23, and 580-5-30A/B</li> </ul>	<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum</li> </ul>
<b>Environmental Accessibility Adaptations</b>	<ul style="list-style-type: none"> <li>Contractor</li> </ul>	<ul style="list-style-type: none"> <li>Meets all applicable State and Local Licensure requirements</li> </ul>		<ul style="list-style-type: none"> <li>All construction, wiring, plumbing meets applicable building codes</li> </ul>

SERVICE	• PROVIDER	• LICENSE	CERTIFICATION/ACCREDITATION	OTHER STANDARD
<b>Skilled Nursing</b>	<ul style="list-style-type: none"> <li>Registered Nurse</li> </ul>	<ul style="list-style-type: none"> <li>Code of Alabama, 1975 Sec. 34-21</li> </ul>		<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Specialized Medical Equipment and Supplies</b>	<ul style="list-style-type: none"> <li>Individuals and Businesses able to supply and service supplies and equipment.</li> </ul>			<ul style="list-style-type: none"> <li>Meet same standard as providers under the State Plan EPSDT program.</li> </ul>
<b>Speech and Language Therapy</b>	<ul style="list-style-type: none"> <li>Speech Therapist</li> </ul>	<ul style="list-style-type: none"> <li>Code of Alabama, 1975 Sec. 34-28A-1, Ch. 870-x-1-7</li> </ul>		
<b>Physical Therapy</b>	<ul style="list-style-type: none"> <li>Physical Therapist</li> </ul>	<ul style="list-style-type: none"> <li>Code of Alabama, 1975 Sec. 34-24-212</li> </ul>		
<b>Occupational Therapy</b>	<ul style="list-style-type: none"> <li>Occupational Therapist</li> </ul>	<ul style="list-style-type: none"> <li>Code of Alabama, 1975 Sec. 34-39-5</li> </ul>		
<b>Behavior Therapy</b>	<ul style="list-style-type: none"> <li>Board Certified Ph.D. or MA level Behavior Analyst, or</li> <li>Ph.D. psychologist without Board Certification, or</li> <li>MA psychologist without Board Certification, or</li> <li>QMRP or BA level Associate Behavior Analyst</li> </ul>		<ul style="list-style-type: none"> <li>Behavior Analysis Certification Board (<a href="http://www.BABC.com">www.BABC.com</a>)</li> </ul>	<ul style="list-style-type: none"> <li>and three years experience working with persons with disabilities.</li> <li>And three years experience working with persons with disabilities and under supervision</li> <li>Qualify as a QMRP, 42 CFR 483.430; with training and experience in applied behavioral analysis / positive behavior support.</li> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Community Specialist Services</b>	<ul style="list-style-type: none"> <li>BA level QMRP with special training and experience</li> </ul>			<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum,</li> </ul>
<b>Crisis Intervention</b>	<ul style="list-style-type: none"> <li>Team directed by Graduate</li> </ul>			<ul style="list-style-type: none"> <li>See Appendix B-2 Addendum,</li> </ul>

	Psychologist or Social Worker			
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B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure of certification requirements are met for services individuals furnishing services that are provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

**DMH/MR CONTRACT: PROVIDER REQUIREMENTS**

All waiver providers must have a contract with the Department of Mental Health and Mental Retardation (DMH/MR) for the delivery of the specific service(s) they will provide. Providers may not enroll with Medicaid as a waiver provider without first obtaining a contract with DMH/MR. The provider must maintain a current contract in order to continue as an active waiver provider.

**QUALITY ASSURANCE**

- A. Certification standards are published in the Alabama State Code. These are the standards for certification of residential and day habilitation, prevocational and supported employment providers. The certification process administered by the DMH/MR allows high scoring providers to be certified for two years; successful but lower scoring providers to be certified for one year, and sets up a process for conditional certification with possible termination for those providers which do not achieve a satisfactory certification.
- B. The Division of Mental Retardation maintains 5 regional community service offices which house Continuous Quality Improvement (CQI) staff as well as other professional staff who provide technical assistance and monitoring to community providers. Other officials of the DMH/MR housed at the community service offices are Advocates, which conduct investigations.  
  
If a provider refuses to cooperate in taking corrective action, the Division can initiate intermediate sanctions such as discouraging new admissions or encouraging the development of new providers in the area. When necessary, the Division can remove individuals from services and terminate a provider's DMH/MR contract if necessary.
- C. The Division of Mental Retardation has joined other state MRDD agencies participating in the NASDDDS/HSRI sponsored Core Indicators project. The initial effort will be to implement a consumer and family survey process using volunteer consumers and family members. Volunteers will schedule visits with the permission of the person and throughout the process maintain focus on the person and his or her choices, inclusion, rights, dignity, and quality of life. The purpose will be to determine if the individual is leading as full a life as possible, not to review local, state or federal standards.
- D. The Alabama Department of Medicaid conducts surveys of all waiver providers and case management agencies as well. Findings are shared with the DMH/MR for technical assistance and follow-up, unless serious problems are found. In such a case the DMH/MR would initiate either an investigation or a targeted certification review, as necessary.



**ADDITIONAL SERVICE STANDARDS**

**PERSONAL CARE SERVICES**

**Provider Qualifications**

Personal care workers may be employed by, or under contract with, any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals, that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QMRP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting. The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law,
- Provide training and supervision as required by this scope of services,
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care,
- Implement a plan and method for providing backup at any time it is needed,
- Implement and assure the person and his or her family are and remain satisfied with the service.

**Personal Care Workers:**

- Must have at least two references from work and/or school, and one personal, which have been verified by the provider agency.
- Must have background checks required by law and regulation.
- Must be at least 18 years of age.
- Must be able to read and write and follow instructions.
- Must have at least completed tenth grade.
- Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
- Must have no physical or mental impairment that would prevent providing the needed assistance to the person.
- If providing transportation, must have valid driver's license and insurance as required by State Law.

Personal Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported, nor shall they be in any other way legally obligated to provide the service. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care and, as for all other personal care workers, payment shall only be made for services actually rendered. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

**Training Requirements**

This service is intended to promote self-determination of waiver participants. To the extent practical, safe and cost effective, the individual and his family are encouraged to exert choice in planning, and in the selection and hiring of staff, and are encouraged to provide training and supervision to the worker(s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

Procedures and expectations related to the personal care worker, including following the Personal Care Plan of Care, the rights and responsibilities of the provider and the consumer, reporting and record keeping requirements, procedures for arranging backup when needed, and who to contact within the provider agency or regional office.

- Information about the specific condition and needs of the person to be served, including his or her physical, psychological or behavioral challenges, his or her capabilities, and his or her support needs and preferences related to that support.
- Training in CPR and first aid and, if administration of ordinarily self-administered medication is required by the consumer, training in medication administration. As needed due to challenging behavior by the consumer, the worker will also be trained in behavioral intervention techniques appropriate to the consumer. Training in medication administration and behavior intervention techniques may be waived if not required to support the person.
- Training in communication skills; in understanding and respecting consumer choice and direction; in respecting the consumer's confidentiality, cultural and ethnic diversity, personal property and familiar and social relationships; in handling conflict and complaints and in responding to emergencies.
- Training in assisting with activities of daily living and instrumental activities of daily living, as needed by the consumer and identified by the planning team.
- The provider will maintain a record of training.

### **Supervision**

Supervision shall not be left solely to the family or individual, even though family and individual are in most instances entirely competent to provide such supervision. A QMRP from the provider agency must visit the person, in person, at least every 90 days. The planning team shall recommend a visit schedule in the personal care

addendum. The visiting QMRP shall make an assessment of the effectiveness of the service, the consumer satisfaction with the service, and of any changes that may need to be made, including additional training or a change in the plan of care. This record shall be shared with the provider agency and the individual and his or her family.

### **Documentation**

The direct service provider and/or billing provider must maintain documentation of the dates and hours of service provided, and of the service activities provided within each span of work showing that services delivered are consistent with the recipient's individual plan of care. Daily or weekly logs, signed by the worker and by the consumer or family member, which identify the consumer and the consumer's Medicaid number, the worker providing the service, the date(s) of service, the time service began and the time service ended, and the specific activities provided within each span of work, will be acceptable as a minimum. In addition, there must be evidence of a quarterly review of the services provided and of the continued appropriateness of those services by a QMRP.

### **RESPITE CARE**

#### **Respite Care provided in a person's home**

##### **Provider Qualifications**

Respite care workers may be employed by any agency qualified to provide services under the waiver, and by home health and other home care agencies, and individuals, that may not otherwise be waiver providers. Any agency or individual undertaking the provision of this service must employ or contract with a QMRP to provide the required supervision and must meet the other requirements of this addendum related to training, plans of care, documentation and reporting.

The primary requirements for the provider agency are to:

- Handle all payroll taxes required by law,
- Provide training and supervision as required by this scope of services,
- Maintain records to assure the worker was qualified, the service was provided and provided in accordance with the plan of care,
- Implement a plan and method for providing backup at any time it is needed,
- Implement and assure the person and his or her family are and remain satisfied with the service.

Respite Care Workers:

- Must have background checks required by law and regulation.
- Must be at least 18 years of age.

- Must be able to read and write and follow instructions.
- Must have at least completed tenth grade.
- Must be able to follow the plan of care with minimal supervision unless there is a change in the person's condition.
- Must have no physical or mental impairment that would prevent providing the needed oversight and care to the person.

Respite Care Workers shall not be members of the immediate family (parents, spouses, children or siblings) of the person being supported. Any other relatives, or friends, who are employed to provide services shall meet the qualifications for providers of care. Employment of a relative or friend shall be noted and justified in the consumer's record by the provider agency.

### **Training Requirements**

To the extent practical, safe and cost effective, the individual and his family are encouraged to exert choice in the selection and hiring of staff, and are encouraged to provide training to the worker(s). Agencies are encouraged to partner with individuals and families in this endeavor, while providing a safe and effective backup system to meet contingencies.

Training shall be provided prior to the worker delivering services and includes:

1. The rights and responsibilities of the provider and the consumer, procedures for billing and payment, record-keeping requirements and who to contact within the regional center.
2. Information about the specific condition and needs of the person to be served, and training in the care and assistance the respite worker will need to provide.
3. Training or verification of training in CPR and first aid and, if needed, training in medication administration and/or behavioral intervention techniques approved by the regional centers (these include MANDT techniques and PCI--Physical Crisis Intervention).

The provider will maintain a record of training.

### **Supervision**

A QMRP from the provider agency must accompany a new worker to his or her first assignment, to observe and assist as the ordinary caregiver tells the worker what needs to be done to support the person being cared for. The QMRP may leave when the caregiver does, but needs to debrief the worker within a week after the assignment is completed. Additional visits may need to be made to assist the worker, especially with situations where the respite is to be provided to a person with special medical or behavioral needs or problems. Supervision must be tailored to the individual being

served. The supervisor shall either be on call for the worker while respite is being provided or shall ensure the worker has a back-up number to call. The supervising QMRP shall record an assessment of the worker's competence and comfort working with people with mental retardation, and shall always contact a family served by the worker to determine and record their satisfaction with the service and any other information they wish to share.

**Documentation**

The billing provider must maintain documentation of the days and hours of service provided. Logs signed by the worker and cosigned by the consumer or family member are acceptable.

**RESIDENTIAL HABILITATION SERVICES (Provided in a person's own home)**

The Department of Mental Health and Mental Retardation, Division of Mental Retardation requires certification of programs delivering Residential Habilitation services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B.

The provider of residential rehabilitation is a certified community residential agency, who will be responsible for employing, training and supervising habilitation aides to provide individual habilitation under the supervision of and direct assistance by a QMRP, who is also employed by the certified community residential agency.

An applicant wishing to provide Residential Habilitation Services under the Living at Home Waiver does not need to provide evidence of compliance with fire and health standards because the service will be provided in the individual's home (including family home). Instead, a new applicant shall submit to the Division a written plan in the form of a proposal, together with an application for programmatic certification, describing how the programmatic standards referenced above will be met. Designated staff will review the application and proposal and when applicant and staff are in agreement, staff will recommend initial certification to the Associate Commissioner for Mental Retardation. Subsequent certification inspections will take place on site in the consumer's home, with the permission of the consumer/family.

An applicant who is already certified to provide Residential Habilitation in a facility does not need to submit an application and proposal to provide services under this waiver. Instead, the provider should simply contact the regional community service office of the Division, expressing an interest in enrolling. Initial certification for this service will be deemed; when a certification inspection is due, a sample of inspections will take place in the consumer's home, with the permission of the consumer/family.

Programs delivering Residential Habilitation services shall have written mission statement for dissemination to prospective clients and their families. This mission statement shall address the following:

Program philosophy and purpose;  
Geographical area served;  
Range of services provided; and  
Population served, including criteria for service  
eligibility,  
program admission and program discharge.

Program staff ratios and staff work schedules shall be maintained to meet the needs of the client. An emergency, on-call staff person shall be available. Staff scheduling and work place assignments shall be so arranged as to provide continuous on-site response capability in the event of client needs. The staffing pattern shall be appropriate to the type and scope of programmed services. Staff shall meet qualifications in the approved job descriptions.

Residential Habilitation training services will be delivered/supervised by a Qualified Mental Retardation Professional in coordination with the individual's plan of care.

**Habilitation Aide - Residential Habilitation Training**

The Aide will work under supervision and direction of a Qualified Mental Retardation Professional. The QMRP must provide and document supervision of, training for, and evaluation of Aide in the individual client's record. The QMRP must assist the Aide as necessary as they provide individual habilitation services as outlined by the plan of care.

**Minimum Qualifications:**

The Aide must be 18 years of age and must possess a high school diploma or G.E.D.

**Training Requirements:**

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR that will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of mental retardation and developmental disabilities.
3. Concepts of human development.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above. Providers must have documented record

of having completed training prior to providing services. Providers of service must maintain a service log that documents specific dates on which services were delivered, consistent with the consumer's plan of care.

**DAY HABILITATION, PREVOCATIONAL, and SUPPORTED EMPLOYMENT SERVICES**

The Department of Mental Health and Mental Retardation, Division of Mental Retardation requires certification of programs delivering Day Habilitation, Prevocational and Supported Employment services. Standards are in Alabama Code, Chapters 580-3-23, and 580-5-30 A and B.

An applicant wishing to provide any one or combination of these services must provide written statements of the program facility's compliance with fire and health standards and submit these and other documentation to the Division of Mental Retardation. Designated staff will review the certification application and when in agreement will so indicate to the Associate Commissioner for Mental Retardation. The MR regional offices will coordinate with concerned Department Offices, including the Division of Technical Services, Certification Office and will schedule site visits and other procedures.

When the application, supporting data, and site visit prove the program or service is in full compliance with certification requirements, a certification certificate will be issued by the Associate Commissioner for Mental Retardation.

Subsequent site inspections shall be scheduled in accordance with policy and procedures of the MR regional office and the Department's Division of Technical Services.

Programs delivering Day Habilitation, Prevocational and/or Supported Employment services shall have written mission statements for dissemination to prospective clients and their families. The mission statement shall address:

- Program philosophy and purpose;
- Geographical area served;
- Range of services provided; and
- Population served, including criteria for service eligibility, program admission and program discharge.

The staffing pattern shall be appropriate to the type and scope of program services and shall include staff members who meet the experiential and educational qualifications set forth in the approved job descriptions. The program shall develop and maintain appropriate, up-to-date staffing schedules. Staff to client daily ratio shall not be more than 1:15. No client shall ever be left unsupervised unless the activity is part of a structured activity or individual activity plan (IAP).

**Day Habilitation Training: Requirements specific to this service.**

**Habilitation Aide - Job Specifications**

Day Habilitation training services will be delivered by a habilitation aide and supervised by a Qualified Mental Retardation Professional (QMRP) in coordination with the individual's plan of care.

The Aide will work under supervision and direction of a Qualified Mental Retardation Professional. The QMRP must provide and document supervision of, training for, and evaluation of Aide in the individual client's record. The QMRP must assist the Aide as necessary as they provide individual Habilitation services as outlined by the plan of care.

**Minimum Qualifications:**

Must be 18 years of age and must possess a high school diploma or G.E.D.

**Training Requirements:**

Prior to assignment, each Habilitation Aide will be required to be certified by the provider agency as having completed a course of instruction provided or approved by the DMH/MR which will minimally include:

1. Recipient rights and grievance procedures.
2. Overview of mental retardation and developmental disabilities.
3. Concepts of human development.
4. CPR, first aid, medical emergencies.
5. Management of challenging behavior.
6. Physical management techniques.
7. Health observation, including hygiene, medication control/ universal precautions.
8. Recipient abuse, neglect and mistreatment.
9. Habilitation training programs.

Retraining will be conducted as needed, but at least annually for training requirements 1, 5, 6, 7 & 8 above.

**PREVOCATIONAL SERVICES: Requirements specific to this service.**

In addition to certification, the following requirements apply to the provider's staff.

**Activity Program Aide: Job Specifications**

The minimum requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree with a major concentration in rehabilitation, industrial arts, pre-vocational education, psychology or a related field is preferred along with experience supervising or training and knowledge of persons with disabilities.

**Specific Duties:** The Activity Program Aide will work under the supervision and direction of a QMRP. The QMRP will provide and document on-site supervision every 30 days. Supervisor reports must be maintained



in the personnel file and are subject to review by DMH/MR and Alabama Medicaid Agency.

The duties of the Activity Program Aide (Pre-Vocational) include:

1. Instructs/demonstrates/interacts with clients concerning a variety of education, personal care, pre-vocational training, job safety, and social behaviors, in accordance with the individual's habilitation plan and program requirements. Uses sound judgment and abides by supervisor's instructions, minimum standards and other applicable regulatory standards in order to foster client self-sufficiency and independence.
2. Converses with/listens to clients concerning personal needs, responsibilities, expectations, aspirations, privileges, and personal/behavioral problems in a supportive and understanding manner.
3. Participates in developing, modifying, and adapting instruction and training to individual client needs.
4. Interacts often and appropriately with clients using both verbal and nonverbal methods (gestures, modeling, sign language, etc.) to provide information to clients about expected behavior, duties, and activities.
5. Observes the quality of production and integrates efficiency concepts in the work process.
6. Provides/receives information to/from peers, supervisors, other professional staff, support personnel, and clients pertaining to care plan, schedules, programs, and progress using personal contacts, meetings, memorandums, reports, records and filing systems in accordance with established schedules in order to facilitate client training, record maintenance and the exchange of other pertinent information.
7. Assists in computing data for programs such as behavior management, speech, token reinforcement, vocational, and social in order to assess client progress.

#### **Training Requirements**

The Activity Program Aide (Pre-Vocational) training should demonstrate interaction with recipients concerning education, personal care, pre-vocational training, job safety and social behaviors, in accordance with the recipient's habilitation plan and care plan. The minimum training requirements:

1. Planning and coordinating all activities according to the individual habilitation and care plan.

2. Leadership with recipients doing therapeutic or rehabilitative activities programs.
3. Conferring with other professional personnel concerning the progress and needs of the recipients.
4. Providing individual instruction when needed.
5. Health observation including hygiene medication control/universal precautions.
6. Recipient abuse, neglect and mistreatment.
7. Knowledge of equipment and supplies needed for assigned activities.
8. Recipients rights and grievance procedures.
9. CPR first aid, medical emergencies.
10. Training on how to read and comprehend written materials, such as the care plan, habilitation plans and policy and procedures manuals.

Ongoing training will be conducted as needed but at least annually for above training requirements 6 and 8.

**Additional Provider Requirements**

The provider of service

- Must have required training prior to providing service;
- Must keep record of required training in the personnel folder; and
- Must maintain a service log that documents specific days on which services were delivered consistent with the recipient's individual plan of care.

**SUPPORTED EMPLOYMENT SERVICES: Requirements specific to this service.**

In addition to certification, the following requirements apply to the provider's staff.

**Job Trainer (Job Coach): Job Specifications**

**QUALIFICATIONS:**

The minimal requirement for this position is graduation from high school or its equivalent and two years work experience. A Bachelors Degree, preferable with a major concentration in rehabilitation, industrial arts, vocational education, psychology or a related field is preferred. Work experience of a supervisory or training nature as well as knowledge of persons with disabilities would be particularly desirable.

**GENERAL OUTLINE:**

The Job Trainer is responsible to the Program Director for the training and associated support services necessary to ensure the successful employment of clients involved in Supported Employment.

**SPECIFIC DUTIES:**

The duties of the Job Trainer (Job Coach) include:

1. Training supported work clients to perform specific jobs consistent with their abilities;
2. Working with employers to modify or adapt job duties or work stations so supported work clients can have the maximum opportunity for job success. This may involve job and task analysis, employer interviews, and actual job performance to insure a thorough understanding of the specific job and general job rules prior to placement of the client:
3. Teaching clients associated work skills, responsibilities and behaviors not related to the specific job being performed, such as how to complete a time card, when and where to take bathroom and lunch breaks, safety precautions, etc.;
4. Assisting each client placed in a job training program to become an integrated member of the work force. This may happen in the general course of the job but could require activity such as encouragement of the client worker or other employees to communicate with each other, or the provision of disability awareness of training to worker's of the company;
5. Working with client to be placed in employment and/or with client's family or residential provider to insure that client has reliable transportation to and from work, adequate housing, and emotional support for client's job efforts;
6. Making every effort to insure that the supported work client and the job are satisfactory matched by thoroughly getting to know each client prior to job placement. This may include reviewing current progress in client's present program placement, studying referral information, and working with client to assess work skills;
7. Communicating through written and oral reports on progress of Supported Work Clients to Program Director and other program staff; follow oral or written instructions (such as the care plan or rehabilitation plan);
8. Providing continued ongoing support to supported work clients;
9. Performing other job duties necessary to ensure the success of Supported Work Clients as well as any additional tasks assigned by the Program Director that will be of benefit to other clients in the program.
10. Works under the direction of a QMRP.
11. Providers of service must maintain a service log that documents specific days and hours on which supported employment services were delivered. Provider qualifications are found in Appendix B-2.

**TRAINING REQUIREMENTS:**

The training program for the Job Coach will reinforce the responsibility to ensure successful employment of recipients involved in supported employment. The Job Coach will be required to be certified by completing the requirements provided by a QMRP, approved by DMH/MR. Training completion must be documented and is subject to review by DMH/MR and Alabama Medicaid. Minimum training requirements must include the following areas:

1. Overview of mental retardation and developmental disabilities
2. Skills to identify recipient abuse, neglect and mistreatment
3. Recipients rights and grievance procedures
4. Oral and written instructions regarding care plan
5. Planning and conducting appropriate activities

Ongoing training will be conducted as needed but at least annually for training requirements 2 and 3 above.

#### **SKILLED NURSING**

The provider shall be a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

The service(s) of the nurse must be documented by a nursing note that includes the identity and Medicaid number of the consumer, the date of service, the beginning and ending time of the service, and the nursing service(s) provided within that time. In addition the nursing note should include, as appropriate, the nurse's assessment, changes in consumer's condition, follow-up measures, communications with family, care-givers or physicians, training or other pertinent information. The nurse must sign and date the note.

#### **BEHAVIOR THERAPY SERVICES PROVIDER QUALIFICATIONS**

Three levels of provider may provide Behavior Therapy. The qualifications are as follows:

**Level 1:** Providers must have either a Ph.D. or M.A. and be certified as a Behavior Analyst (BCBA) by the Behavior Analysis Certification Board.

Behavior Analysis Certification Board  
3323 Thomasville Road, Suite B  
Tallahassee, FL 32308  
Phone (850) 386-4444; FAX (850) 386-2404; Web [www.BACB.com](http://www.BACB.com)

**Level 2:** Providers must have either a Ph.D. or M.A. in the area of Behavior Analysis, Psychology, Special Education or a related field and three years experience working with persons with Developmental Disabilities. Level 2 providers with a Doctorate do not require supervision. Master's degreed individuals require supervision averaging two hours per week by a Level 1 provider or a Level 2 Ph.D. provider.

**Level 3:** Providers must be either a QMRP (per the standard at 43 CFR 483.430) or be a Board Certified Associate Behavior Analyst (BCABA). With

APPENDIX B - SERVICES AND STANDARDS  
APPENDIX B 2 PROVIDER QUALIFICATIONS

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Two years of experience and authorization by the Administering Agency, the BCABA may qualify as a Level 2 provider with supervision.

All Behavior Therapy service providers must complete an Orientation Training. This will consist of training to ensure providers are aware of the minimum standards of practice outlined in the Behavioral Services Procedural Guidelines adopted by the Department. Areas of training are: Levels of Risk; Levels of Intervention; Behavior Program Review Committee; Data Collection, Graphing, and Reporting. The Behavior Support Plan (Content & Process) will also be trained.

The orientation of Level 1 and level 2 providers will be provided by the DMH/MR. With approval of DMH/MR, level 1 and level 2 providers can then provide the orientation to level 3 providers and also to other

Professional Level providers. The DMH/MR will maintain a registry of trained Behavior Therapy Providers and record of their orientation. The DMH/MR will also maintain a record of who is providing the supervision to those level 2 non-Ph.D. providers and level 3 providers who require supervision.

**COMMUNITY SPECIALIST SERVICES**

The provider must meet federally defined QMRP qualifications (42 CFR 438.430) and be free of any conflict of interest. This means he or she cannot work for any provider or provider agency from which a person is receiving, or is likely to receive, services reimbursed through this waiver program.

In addition, the provider must have experience, verified by the DMH/MR, in person centered planning. This will consist of both training and actual practice.

**CRISIS INTERVENTION**

Providers of crisis intervention shall consist of a team under the direction and supervision of a psychologist, counselor or social worker licensed by the State of Alabama, and meeting the requirements of a QMRP (as defined at 42 CFR 483.430). All team members shall have at least one year of work experience in serving persons with developmental disabilities, and shall, either within their previous work experience or separately, have a minimum of 40 hours training in crisis intervention techniques prior to providing services. The team shall be mobile and prepared to provide direct staffing if that is necessary to implement the plan.

Crisis teams may be agency based (certified waiver residential and day habilitation providers, or DMH/MR Developmental Centers), or they may stand alone. Because this is a new service, the initial teams will be employed by the DMH/MR Developmental Centers, because of the knowledge and experience in crisis prevention and intervention gained by staff of these facilities. The time and expenses of these staff when operating in the community or otherwise on behalf of a waiver recipient, will be maintained in a separate cost center to segregate these costs from the ICF/MR program.

**APPENDIX B - SERVICES AND STANDARDS**  
**APPENDIX B 3 - KEYS AMENDMENT STANDARDS**

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**KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES**

**KEYS AMENDMENT ASSURANCE**

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

**APPLICABILITY OF KEYS AMENDMENT STANDARDS:**

Check one:

☐ Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

☒ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

**Community Residential Facilities, in which out of home respite may be provided, are certified by DMH/MR. Similarly, ICFs/MR and Hospitals, in which respite may also be provided, are certified by the Department of Public Health.**

SECTION 1915 (c) WAIVER **FORMAT**

**APPENDIX C-Eligibility and Post-Eligibility**

**Appendix C-1--Eligibility**

**MEDICAID ELIGIBILITY GROUPS SERVED**

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1.   **X**   Low income families with children as described in section 1931 of the Social Security Act.
2.   **X**   SSI recipients (SSI Criteria States and 1634 States).
3.            Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).
4.            Optional State supplement recipients
5.            Optional categorically needy aged and disabled who have income at (Check one):
  - a.            100% of the Federal poverty level (FPL)
  - b.            % Percent of FPL which is lower than 100%.

6. \_\_\_\_\_ The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

\_\_\_\_\_ A. Yes

\_\_\_\_\_ B. No

Check one:

- a. \_\_\_\_\_ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or
- b. \_\_\_\_\_ Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) \_\_\_\_\_ A special income level equal to:

\_\_\_\_\_ 300% of the SSI Federal  
benefit (FBR)

\_\_\_\_\_ % of FBR, which is lower than  
300% (42 CFR 435.236)

\$ \_\_\_\_\_ which is lower than 300%

(2) \_\_\_\_\_ Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI



program.(42 CFR 435.121)

(3) \_\_\_\_\_ Medically needy without spenddown  
in States which also provide  
Medicaid to recipients of SSI. (42  
CFR 435.320, 435.322, and  
435,324.)

(4) \_\_\_\_\_ Medically needy without spenddown  
in 209(b) States.(42 CFR 435.330)

(5) \_\_\_\_\_ Aged and disabled who have income  
at:

a. \_\_\_\_\_ 100% of the FPL

b. \_\_\_\_\_ % which is lower than 100%.

(6) \_\_\_\_\_ Other (Include statutory reference  
only to reflect additional groups  
included under the State plan.)

7. \_\_\_\_\_ Medically needy (42 CFR 435.320, 435.322, 435.324 and  
435.330)

8. \_\_\_\_\_ All other mandatory and optional groups under the plan  
are included.

9.

    **X**    

SSI Related Protected Groups Deemed to be Medicaid Eligible. These groups include:

Those individuals who are not eligible for SSI because their income exceed the Federal Benefit Rate (FBR) due to certain Title II COLA's received after April 1977. (42 CFR 435.135)

A widow/widower between the ages of 50 and 59 who would be eligible for SSI except for entitlement to Social Security and who are not receiving Medicare. (P.L. 99-27251202 and P.L. 100-203, S 9108)

A widow/widower between the ages of 60 and 65 who lost SSI as a result of receiving Social Security and who are not receiving Medicare (P.L. 100-203, S 9116).

An individual who lost their SSI benefits upon entitlement to or increase in child's insurance benefits based on disability. These are individuals who began receiving an increase in Social Security benefits as a disabled adult child. (P.L. 99-643).

**Appendix C-2--Post-Eligibility**

**POST ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1. \_\_\_\_\_ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

A. **\$ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A. \_\_\_\_\_ The following standard included under the State plan (check one):

(1) \_\_\_\_\_ SSI

(2) \_\_\_\_\_ Medically needy

(3) \_\_\_\_\_ The special income level for the institutionalized

(4) \_\_\_\_\_ The following percent of the Federal poverty level): \_\_\_\_\_ %

(5) \_\_\_\_\_ Other (specify): \_\_\_\_\_

B. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_ \*

\* If this amount changes,  
this item will be revised.

C. \_\_\_\_\_ The following formula is used  
to determine the needs  
allowance:

**Note:** If the amount protected for waiver  
recipients in item 1. is **equal to, or greater  
than** the maximum amount of income a waiver  
recipient may have and be eligible under 42 CFR  
435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A. \_\_\_\_\_ SSI standard

B. \_\_\_\_\_ Optional State supplement  
standard

C. \_\_\_\_\_ Medically needy income  
standard

D. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_ \*

\*If this amount changes, this  
item will be revised.

E. \_\_\_\_\_ The following percentage of  
the following standard that  
is not greater than the  
standards above: \_\_\_\_\_ % of  
standard.

F. \_\_\_\_\_ The amount is determined  
using the following formula:

G. \_\_\_\_\_ Not applicable (N/A)

3. Family (check one):

- A. \_\_\_\_\_ AFDC need standard
- B. \_\_\_\_\_ Medically needy income  
standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the States approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

- C. \_\_\_\_\_ The following dollar amount:  
\$ \_\_\_\_\_ \*

\*If this amount changes, this item will be revised.

- D. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: % \_\_\_\_\_ of \_\_\_\_\_ standard.

- E. \_\_\_\_\_ The amount is determined using the following formula:

- F. Other

- G. \_\_\_\_\_ Not applicable (N/A)

- b. Medical and remedial care expenses specified in 42 CFR 435.726.

**POST-ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1. (b) \_\_\_\_\_ **209(b) State, a State that is using more restrictive eligibility requirements than SSI.** The State is using the post-eligibility rules at 42 CFR 435.735. Payment for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipients income.

B. **42 CFR 435.735--States using more restrictive requirements than SSI.**

(a) Allowances for the needs of the

(1) individual: (check one):

A. \_\_\_\_\_ The following standard included under the State plan (check one):

(1) \_\_\_\_\_ SSI

(2) \_\_\_\_\_ Medically needy

(3) \_\_\_\_\_ The special income level for the institutionalized

(4) \_\_\_\_\_ The following percentage of the Federal poverty level: \_\_\_\_\_ %

(5) \_\_\_\_\_ Other (specify):

B. \_\_\_\_\_ The following dollar amount:  
\_\_\_\_\_ \*

\* If this amount changes, this item will be revised.

C.\_\_\_\_\_ The following formula is used  
to determine the amount:

**Note:** If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under \$435.217, **enter NA in items 2. and 3.** following.

2. spouse only (check one):

A.\_\_\_\_\_ The following standard under  
42 CFR 435.121:

B.\_\_\_\_\_ The medically needy income  
standard\_\_\_\_\_;

C.\_\_\_\_\_ The following dollar amount:  
\$\_\_\_\_\_\*

\*If this amount changes, this  
item will be revised.

D.\_\_\_\_\_ The following percentage  
of the following standard  
that is not greater than  
the standards above:  
\_\_\_\_\_ % of

E.\_\_\_\_\_ The following formula is used  
to determine the amount:

F.\_\_\_\_\_ Not applicable (N/A)

3. family (check one):

A.\_\_\_\_\_ AFDC need standard

B.\_\_\_\_\_ AFDC payment standard

C.\_\_\_\_\_ Medically needy income  
standard

D.\_\_\_\_\_ The following dollar amount:

\$ \_\_\_\_\_ \*

\*If this amount changes, this item will be revised.

E. \_\_\_\_\_ The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of standard.

F. \_\_\_\_\_ The following formula is used to determine the amount:

G. \_\_\_\_\_ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.



**POST ELIGIBILITY**

**SPOUSAL POST ELIGIBILITY**

2. \_\_\_\_\_ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution towards the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual: (check one)

(1) \_\_\_\_\_ Institutional PNA: Specify the amount: \$ \_\_\_\_\_ \*

\*Explain why you believe this amount is reasonable to meet the maintenance needs of the individual in the community:

(2) \_\_\_\_\_ An amount which is comparable to the amount used as the maintenance allowance of the individual for home and community based waiver recipients who have no community spouses. (check one):

(a) \_\_\_\_\_ SSI Standard

(b) \_\_\_\_\_ Medically Needy Standard

(c) \_\_\_\_\_ The special income  
level for the  
institutionalized

(d) \_\_\_\_\_ The following  
percent of the  
Federal poverty  
level: \_\_\_\_\_ %

(spouse) \_\_\_\_\_ Other  
(specify):

(f) \_\_\_\_\_ The following  
dollar amount \$ \_\_\_\_\_ \*\*

\*\*If this amount changes,  
this item will be revised.

(g) \_\_\_\_\_ The following  
formula is used to  
determine the  
needs allowance:

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS  
APPENDIX D 1- Evaluation of LEVEL OF CARE

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a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

- ☐ Discharge planning team
- ☐ Physician (M.D. or D.O.)
- ☐ Registered Nurse, licensed in the State
- ☐ Licensed Social Worker
- ☒ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
- ☐ Other (Specify):

**APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS**  
**APPENDIX D 1- Evaluation of LEVEL OF CARE**

**VERSION 06-95**

**Addendum to Appendix D-1: Procedures by which people apply for and are determined eligible or not-eligible for the Home and Community-Based Waiver.**

Evaluations of level of care may be developed by community organizations and submitted to the DMH/MR regional community service offices. Test instruments used must be standard, widely accepted, and must measure the IQ and adaptive functioning level of the individual. Individuals providing evaluations and assessments for community service organizations must be trained and meet all qualifications to administer such tests. Specialized assessments regarding individual needs of the person may also be used to measure comparisons with age, functioning level, and other disabilities (e.g., sensory impairments). DMH/MR's Regional Quality Assurance Section will routinely monitor the qualifications of individuals administering evaluations and assessments to individuals seeking services.

Current collateral assessment information may be gathered and used from other organizations familiar with the individual seeking services (e.g., schools).

Individuals may be referred to the MR regional community service office in the geographic area in which the individual lives or chooses to live in the state, by community service organizations providing waiver services or by any other party. Referral to the MR regional office should include, along with the request for service, any/all tests or assessment information available to the referring agency or party.

The MR regional community service office is responsible for determining the level of care for all individuals seeking waiver services. A QMRP in the MR regional office, which position is the same or comparable to the QMRP who performs the initial level of care evaluation for application to the ICF/MR facility, will review all test or assessment information provided with the referral for waiver services. If the test/assessment information is not complete or is inconclusive regarding the type or level of disabilities of the individual, the QMRP may request additional tests/assessments. The MR regional office will make the level of care determination and notify the referring organizations or party within five working days from receipt of request for services. If additional testing/assessment is needed to make a determination of level of care, the QMRP will notify the referring organization or party, also within five working days of receipt. This action will stop the level of care determination process until the additional information has been received.

If the QMRP in the MR regional office determines that a person seeking waiver services is ineligible for ICF/MR services, he or she notifies, in writing, the referring organization or party and the recipient or family member. The written notice includes the appeal rights. Appeals regarding the determination of level of care are conducted by DMH/MR on behalf of the Alabama Medicaid Agency using appeals procedures approved by the Alabama Medicaid Agency. These procedures include notification to the person and/or his representative that in addition to the DMH/MR appeals process, they may request a fair hearing from the Medicaid Agency. Additionally, the Medicaid Agency will review a random sample of 10% of adverse decisions administered by DMH/MR annually.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

- \_\_\_\_\_ Every 3 months
- \_\_\_\_\_ Every 6 months
- X**   Every 12 months
- \_\_\_\_\_ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

- X**   The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.
- \_\_\_\_\_ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):
- \_\_\_\_\_ Physician (M.D. or D.O.)
- \_\_\_\_\_ Registered Nurse, licensed in the State
- \_\_\_\_\_ Licensed Social Worker
- \_\_\_\_\_ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)
- \_\_\_\_\_ Other (Specify):

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

- ☐ "Tickler" file
- ☐ Edits in computer system
- ☒ Component part of case management
- ☐ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

\_\_\_\_\_ By the Medicaid agency in its central office

\_\_\_\_\_ By the Medicaid agency in district/local offices

  **X**   By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

  **X**   By the case managers

\_\_\_\_\_ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

\_\_\_\_\_ By service providers

\_\_\_\_\_ Other (Specify):

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix. **Two forms are included as an attachment to Appendix D3: the ICF/MR Level of Care Evaluation and the Summary Program of Habilitation.**

The assessment information from which the ICF/MR Level of Care Evaluation is completed is derived from two sources. The Full Scale IQ Score comes from a psychological evaluation, and the functional assessment information comes from the ICAP (Inventory for Client and Agency Planning [Copyright 1986 by the Riverside Publishing Company, 8420 Bryn Mawr Avenue, Chicago, IL 60631]).

The ICAP is a proprietary assessment instrument, widely used in State MR and DD systems as the functional assessment for determining waiver eligibility. In addition to this usage, several states, including Alabama, use the ICAP for setting levels of reimbursement rates.

For eligibility determinations, information from the ICAP automated scoring instrument, the Compuscore, is processed through an algorithm to determine whether or not a person functionally meets the ICF/MR level of care as it applies to Alabama's State Operated Developmental Center. ICAP Domain Scores received by the applicant in specific functional areas are compared to Domain Scores in the same functional areas scaled specifically for the State of Alabama by the authors of the ICAP, to determine if the identified deficit is significant.

When the individual can be served, the Summary Program of Habilitation, together with the Plan of Care, documents the services the person will need to be supported in the community, and how the services will work to meet the person's health and welfare needs.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.



Check one:

  **x**   The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

       The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
    - a. informed of any feasible alternatives under the waiver; and
    - b. given the choice of either institutional or home and community-based services.
  2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.
  3. The following are attached to this Appendix:
    - a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
    - b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
    - c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
    - d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.
- a. **Free choice between Institutional and home and community-based services is documented on the Plan of Care.**
  - b. **Following is a description of the procedures by which eligible individuals or their representatives are informed of the feasible alternatives available under the waiver.**

As part of assessment and service coordination, consumers and/or responsible parties are provided with adequate information to make an informed decision regarding community based care. This process frequently

includes visits to programs and facilities and meetings with multiple providers in the area. Service coordination addresses problems and presents feasible solutions.

Service coordination also includes an exploration of all resources currently utilized by the client, both formal and informal, as well as those waiver services that may be provided to meet the client's needs. If any needs cannot be met, these also are discussed with the individual and his family to fully inform them of the alternatives.

**c. Following is a description of the State's procedures for allowing individuals to choose either institutional or home and community-based services**

Each person served through the waiver must make a written choice of institutional or community-based care, which will remain in effect until such time as the client changes his/her choice. The only exception to making a written choice would occur when the person is not capable of signing the plan of care form and has no legal or responsible party who can sign. In such a case, the case manager must document the reason(s) for absence of a signed choice and the efforts made to locate a responsible party who could have signed for the person.

**d. Following is a description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, subpart E.**

Any waiver applicant or recipient has the right to request a fair hearing if denied home and community-based services or if a decision by the administering agency adversely affects his/her eligibility status or receipt of service. The formal process is in accordance with 42 C.F.R. Section 431, Subpart E and Chapter 3 of the Alabama Medicaid Administrative Code. A Hearing Officer appointed by the Commissioner of the Medicaid Agency conducts fair hearings.

When a change in the individual's needs suggests a change in the waiver services and plan of care, the person's treatment team discuss proposed change(s) with the person and his family/representative prior to implementation. This discussion will include an explanation of the reason for the change, further assessment of the impact of the change, and an effort to elicit agreement on the part of the person and/or his family/representative.

Whenever there is a decision by the administering agency to reduce, suspend, or terminate MR/DD waiver services to coincide with the person's current need, or fitting the service definition, or the person's loss of eligibility for the service, the Department of Mental Health and Mental Retardation (DMH/MR) will issue a written 10 day advance notice to the client and or family/caregiver indicating the client's right to a fair hearing and instructions for initiating an appeal. A copy of the notice will be forwarded to the Medicaid Agency, and it will contain all the due process information required by 42 C.F.R. Section 431, Subpart E.

Attached is the **Dissatisfaction of Services** form which is presented to each waiver participant and his family/representative as part of the planning process, and which each participant or family/representative must sign, acknowledging receipt of the information regarding his/her right to

a hearing.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Records are maintained by the case management agencies and also by the Operating Agency's Regional Offices.

**APPENDIX E - PLAN OF CARE**

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

\_\_\_\_\_ Registered nurse, licensed to practice in the State

\_\_\_\_\_ Licensed practical or vocational nurse, acting within the scope of practice under State law

\_\_\_\_\_ Physician (M.D. or D.O.) licensed to practice in the State

\_\_\_\_\_ Social Worker (qualifications attached to this Appendix)

  **X**   Case Manager

  **X**   Other (specify):  
**Appropriately constituted interdisciplinary team including a QMRP (Qualified Mental Retardation Professional, as defined at [42 CFR 438.430]). A community specialist may serve as the QMRP on the interdisciplinary team.**

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

\_\_\_\_\_ At the Medicaid agency central office

\_\_\_\_\_ At the Medicaid agency county/regional offices

  **X**   By case managers

\_\_\_\_\_ By the agency specified in Appendix A

\_\_\_\_\_ By consumers

  **X**   Other (specify):  
**By Service Providers**

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

\_\_\_\_\_ Every 3 months  
\_\_\_\_\_ Every 6 months  
\_\_\_\_\_ Every 12 months  
  X   Other (specify):

Person centered plans are subject to continuous revision. However, at a minimum, the entire team performs a formal review at least annually. The case manager will maintain at least quarterly contact with each individual or their family or guardian. During quarterly contact, the case manager will monitor the individual's health and welfare. Progress notes will document the contact and whether the outcomes stated in the person's plan are occurring.

It is also the case manager's responsibility to review the provider's notes at least quarterly, and note any problems, discrepancies, dramatic changes or other occurrences that would indicate a need for renewed assessment. The case manager's review of the provider notes will include making further inquiries and taking appropriate action if there is reason to believe the person's health or welfare is potentially at risk.

The Medicaid Agency's Quality Assurance Unit reviews recipient records to ensure the care plans are being reviewed at least every 90 days.

**APPENDIX E - PLAN OF CARE**  
**APPENDIX E 2 - MEDICAID AGENCY APPROVAL**

**VERSION 06-95**

**APPENDIX E-2**

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The Medicaid agency will review a sample of 10% of waiver plans of care (and related documents) monthly. This review by staff from the State Medicaid Agency ensures individuals receiving waived services had a plan of care in effect for the period of time services were provided. They also ensure that the need for services that were provided was documented in the plan, and that all service needs were addressed in the plan of care prior to delivery.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

## APPENDIX F - AUDIT TRAIL

## a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.
2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.
3. Method of payments (check one):
  - ☒ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).
  - ☐ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.
  - ☐ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.
  - ☐ Other (Describe in detail):



**APPENDIX F**

## b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

- a. When the individual was eligible for Medicaid waiver payment on the date of service;
- b. When the service was included in the approved plan of care;
- c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

    **X**     Yes

           No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

    **X**     All claims are processed through an approved MMIS.

           MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A

## **ADDENDUM TO APPENDIX F**

### **b. BILLING PROCESS AND RECORDS RETENTION**

Providers participating in the Living At Home Waiver must have a performing provider agreement with The Department of Mental Health and Mental Retardation and be enrolled with The Alabama Medicaid Agency. The agreement with DMH/MR must be in place prior to enrollment with Medicaid and will serve as verification that the provider meets all the qualifications and standards in the approved waiver document. The Medicaid Agency's fiscal agent enrolls providers for the Medicaid agency. Once the enrollment forms are completed and accepted the LHW provider will receive a provider number that must be used when billing for LHW services. The Medicaid agency will issue unique procedure codes for services in the LHW.

Once a person's eligibility for participation in the waiver is established, information is added to the MMIS Waiver Long Term Care (WLTC) file. The appropriate eligibility date segment is added to the WLTC file. All claims for waiver services are edited against the WLTC file to make sure the dates of service fall between the effective dates on the WLTC file and that the provider number matches.

Reimbursement for services in the LHW will be on a fee for service basis. Note that most of the services in the LHW are also in the Alabama MR waiver, and that a majority of the providers in one waiver will be providers in the other as well. The MR waiver has always operated on a cost based reimbursement basis, with each provider having a unique rate for each service, contracted by the DMH/MR. For some services, such as day habilitation, the span of contracted rates in the MR waiver is significant; for other services the span is not so great.

In order to transition providers to a fee for service, the LHW will either assign a flat fee (where contracted rates in the MR waiver are close) or assign a maximum allowable fee and then set a range of acceptable rates less than the maximum allowable. Providers whose contracted rate for the same service in the MR waiver is within that range will bill that same (contracted) rate. Providers whose contracted rate in the MR waiver for the same service is above the range will be restricted to the maximum allowable. Providers whose contracted rate is below the range will be allowed to bill the lowest rate in the range. New providers, or those wishing to add a service for the first time, will be assigned a standard rate within the acceptable range, based on a percentile.

The intent of this mechanism is to move providers toward a common rate, while still being able to assure statewide access to the services.

Individuals receiving services through the LHW will have a plan of care derived from a person-centered plan that lists the waiver services and includes the units, frequency and providers. This plan of care will be approved by DMH/MR, and be subject to review by the State Medicaid Agency, prior to being added to the Medicaid Prior Authorization File. When waiver eligibility has been established and the plan of care added to the Prior Authorization File, an LTC2 will be generated to the provider showing the waiver eligibility dates and the Prior Authorization number. Providers billing for LHW services must use their provider number, the appropriate procedure codes and the Prior Authorization number.

LHW providers will bill the Medicaid fiscal agent (EDS) directly using the HCFA 1500 billing format. Claims submitted electronically are subjected to appropriate edits in the MMIS system to ensure that payment is made only on behalf of those clients who are Medicaid and waiver eligible, and to providers who are enrolled on the date a service was delivered. Medicaid (EDS) will pay the DMH/MR, which will check to be sure the unit rate billed by the provider is in fact the contracted rate and within the acceptable range of rates for that service. The LHW provider will receive payment from DMH/MR as reimbursement for services rendered. An explanation of payment indicating the disposition of billed services will also be sent to the DMH/MR which will forward it to the LHW provider. Payment for LHW services is payment in full and the individual recipient cannot be billed or held responsible.

The following documentation will be maintained to establish a clear audit trail: the person-centered plan, the waiver plan of care, the Prior Authorization file, a history of authorized and paid services by fiscal year, information collected and maintained by the Medicaid MMIS system including copies of all paid and denied claims, Medicaid explanation of payment information, and eligibility information on each client served.

LHW providers are required to maintain financial records and service documentation on each waiver client including the name of the recipient, the recipient's Medicaid number, the name of the individual provider who delivered the service, the date that the service was rendered, the units of service provided, the place of service, attendance and census data collection, progress notes and monthly summaries. Providers must retain records and other information for a period of three years. These records must be accessible to the Department of Mental Health and Mental Retardation, the State Medicaid Agency and other appropriate state and federal officials.

if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

\_\_\_\_\_ The Medicaid agency will make payments directly to providers of waiver services.

  **X**   The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

\_\_\_\_\_ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

  **X**   Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

**The Department of Mental Health and Mental Retardation and community organizations incorporated under Act 310 of the 1967 State Legislature.**

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

**Waiver claims from these providers will be submitted to the same Medicaid Fiscal Agent used by the rest of the Medicaid programs using unique provider numbers and service indicators for tracking. These claims will be adjudicated and paid by the Medicaid Fiscal Agent.**

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

**APPENDIX G - FINANCIAL DOCUMENTATION**

**APPENDIX G-1  
COMPOSITE OVERVIEW  
COST NEUTRALITY FORMULA**

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	<u>6,215</u>	<u>6,968</u>	<u>123,236</u>	<u>1,827</u>
2	<u>10,843</u>	<u>7,247</u>	<u>128,165</u>	<u>1,900</u>
3	<u>10,438</u>	<u>7,537</u>	<u>133,292</u>	<u>1,976</u>
4	<u>14,398</u>	<u>7,838</u>	<u>138,624</u>	<u>2,055</u>
5	<u>14,398</u>	<u>8,152</u>	<u>144,169</u>	<u>2,137</u>

## FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR                      UNDUPLICATED INDIVIDUALS

1                      5692                      5693                      5694                      5695                      569

## EXPLANATION OF FACTOR C:

Check one:

                            The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

  **x**                        The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

                              The State will inform HCFA in writing of any limit which is less than factor C for that waiver year.

**APPENDIX G-2**  
**METHODOLOGY FOR DERIVATION OF FORMULA VALUES**

FACTOR D

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor D as:

"The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following pages.

---

**APPENDIX G-2**  
**FACTOR D**

LOC:

Demonstration of Factor D estimates:

Waiver Year 1\_\_\_\_\_ 2\_\_\_\_\_ 3\_\_\_\_\_ 4\_\_\_\_\_ 5\_\_\_\_\_

Waiver Service	#Undup.Recip (users)	Avg. # Annual Units/User	Avg. Unit Cost	Total
Column A	Column B	Column C	Column D	Column E
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
GRAND TOTAL (sum of Column E):				
TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:				
FACTOR D (Divide total by number of recipients):				
AVERAGE LENGTH OF STAY:				



**APPENDIX G 3 METHODS TO EXCLUDE ROOM & BOARD PAYMENTS****APPENDIX G-3****METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD**

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

- A. The following service(s), other than respite care\*, are furnished in residential settings other than the natural home of the individual(e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements).  
(Specify): **N/A**

\*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

- B. The following service(s) are furnished in the home of a paid caregiver. (Specify): **N/A**

Attached is an explanation of the method used by the State to exclude Medicaid payment for room and board.

**APPENDIX G-4**

**METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES  
OF AN UNRELATED LIVE-IN CAREGIVER**

Check one:

    **X**     The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

           The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

## APPENDIX G-5

## FACTOR D'

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D'. The new definition is:

"The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person's first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

**APPENDIX G-5**

FACTOR D' (cont.)

LOC: ICF/MR

Factor D' is computed as follows (check one):

- \_\_\_\_\_ Based on HCFA Form 2082 (relevant pages attached).
- X**   Based on HCFA Form 372 for years **FY' 2004 & FY 2005** of waiver # **0391.90**, which serves a similar target population.
- \_\_\_\_\_ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.
- \_\_\_\_\_ Other (specify):

## APPENDIX G-6

## FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

"The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

\_\_\_\_\_ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

X \_\_\_\_\_ Based on trends shown by HCFA Form 372 for years **FY 2005** of waiver # **0391.90**, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers. **Note: the average cost from the FY 2005 372 report (the most recent available) was used as a base. This cost was trended forward by 3.4%, which figure was taken from the Bureau of Labor Statistics, Consumer Price Index for August, 2001. The group used was Medical Care in the South Region.**

\_\_\_\_\_ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached.

\_\_\_\_\_ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

\_\_\_\_\_ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor

**G.APPENDIX G-7**

FACTOR G'

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G' as:

"The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person's first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

**APPENDIX G-7**

FACTOR G'

LOC: **ICF/MR**

Factor G' is computed as follows (check one):

\_\_\_\_\_ Based on HCFA Form 2082 (relevant pages attached).

☒ Based on HCFA Form 372 for years **FY 2005** of waiver # **0391.91** which serves a similar target population.  
**Note: the average cost from the FY 2005 372 report (the most recent available) was used as a base. This cost was trended forward by 3.4%, which figure was taken from the Bureau of Labor Statistics, Consumer Price Index for August, 2001. The group used was Medical Care in the South Region.**

\_\_\_\_\_ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

\_\_\_\_\_ Other (specify):

**APPENDIX G FINANCIAL DOCUMENTATION**

**VERSION 06-95**

**APPENDIX G8 DEMONSTRATION OF COST NEUTRALITY**

APPENDIX G-8

DEMONSTRATION OF COST NEUTRALITY

LOC: ICF/MR

YEAR 1

FACTOR D: \$ 6,215  
FACTOR D': \$ 6,968

FACTOR G: \$123,236  
FACTOR G': \$ 1,827

TOTAL: \$13,183 ≤

TOTAL: \$125,063

YEAR 2

FACTOR D: \$10,843  
FACTOR D': \$ 7,247  
TOTAL: \$18,090

FACTOR G: \$128,165  
FACTOR G': \$ 1,900  
TOTAL: \$130,065

≤

YEAR 3

FACTOR D: \$10,438  
FACTOR D': \$ 7,537  
TOTAL: \$17,975

FACTOR G: \$133,292  
FACTOR G': \$ 1,976  
TOTAL: \$135,268

≤

YEAR 4

FACTOR D: \$14,398  
FACTOR D': \$ 7,838

FACTOR G: \$138,624  
FACTOR G': \$ 2,055

TOTAL: \$22,236 ≤

TOTAL: \$140,679

YEAR 5

FACTOR D: \$14,398  
FACTOR D': \$ 8,152

FACTOR G: \$144,169  
FACTOR G': \$ 2,137

TOTAL: \$22,550 ≤

TOTAL: \$146,306

STATE: Alabama

DATE: 10/01/2007



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